Challenge TB – Afghanistan

Year 2
Quarterly Monitoring Report
January-March 2016

Submission date: April 29, 2016

Cover photo: His Excellency, Feruzudin Feruz, Minister of Public Health of Afghanistan, delivering a speech during a TB result conference, March 27, 2016, Kabul Afghanistan, Ministry of Public Health Hall

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Abbreviations

AFB	Acid Fast Bacilli
BPHS	Basic Package of Health Services
CB-DOTS	Community Based DOTS
CBHC	Community Based Health Care
CCM	Country Coordination Mechanism
CHCs	Comprehensive Health Centers
CHWs	Community Health Workers
CTB	Challenge TB
DOT	Direct Observed Therapy
DOTS	Direct Observed Therapy Short Course
EHIS	Evaluation and Health Information System
GCMU	Grant and Contract Management Unit
GF	Global Fund
HCW	Health Care Worker
HFs	Health Facilities
HH	Hand Hygiene
IDP	Internally Displaced Persons
IPT	Isoniazid Preventive Therapy
KNCV	Netherlands' Tuberculosis Organization
Lab	Laboratory
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
NFM	New Funding Module
NGOs	Non-Governmental Organizations
NTP	National Tuberculosis Program
PHO	Provincial Public Health Office
PP	Private Practitioner
PR	Principle Recipient
Q1	Quarter One
Q2	Quarter Two
Q3	Quarter Three
Q4	Quarter Four
QRW	Quarterly Review Workshop
SEHAT	Health Project implementing primary health care
SOP	Standard Operation Procedure
SR	Sub Recipients
STTA	Short Term Technical Assistance
TB	Tuberculosis
TBIC	Tuberculosis Infection Control
TBIS	Tuberculosis Information System
TST	Tuberculosis Skin Test
TVs	Televisions
UNDP	United Nation Development Program
USAID	United States Agency for International Development
USD	United States Dollar
UV	Ultraviolet
VIH	Human Immune Deficiency Virus
WHO	World Health Organization

1. Quarterly Overview

Quarterly Overview

Country	Afghanistan
Lead Partner	Management Sciences for Health (MSH)
Other partners	KNCV Tuberculosis Foundation (KNCV)
Work plan timeframe	October 2015–September 2016
Reporting period	January–March 2016

1.1 Most Significant Achievements

1.1.1 World TB Day celebration

On World TB Day, Challenge TB (CTB) Afghanistan assisted the National Tuberculosis Program (NTP) by advocating for TB at donor, policy, implementation, and community levels in order to increase political commitment to directly observed treatment and short-course (DOTS) expansion and implementation. The largest advocacy event was executed in the capital Kabul, attended by His Excellency Minister of Public Health, USAID Director of Health and Nutrition, other donors, partners, and NTP. The World TB Day celebration was also extended to the community and was celebrated in 368 health facilities (HFs) in 15 provinces. Moreover, CTB helped NTP to develop, print, and distribute 1,100 banners, 3,000 copies factsheets, 35 posters, 500 copies of the NTP annual report, and 500 copies of file folders. Individuals from communities, TB patients, associations and shuras (local councils), community health workers (CHWs), prominent community leaders, community health shuras, religious leaders, government departments, frontline health care workers (HCWs), and civil society members attended these events, with TB messages reaching 18,400 audiences directly. Assuming that each one of these individuals will convey the TB messages to at least three individuals in the community, ultimately 55,200 peoples will be reached indirectly.

USAID mission director delivering a speech during the World TB Day celebration at MOPH conference hall, March 29th, 2016

1.1.2 Execution of TB result conference

CTB Afghanistan assisted NTP to conduct the first ever national TB result conference aimed at promoting evidence-based decision-making and enhancing research within the TB program and health sector at large; informing policy makers, donors, and partners with updated knowledge on TB; and sharing new knowledge (researches, assessments, and results) with the wider academic and public health community in Afghanistan. Through this conference, the NTP shared the new knowledge such as burden of TB among diabetic patients and those in the contacts to a TB patients and effectiveness of sputum and slide sending and role of community volunteers in TB case findings and treatment with policy makers, donors and health care implementing organizations.

This initiative was warmly welcomed and attended by among others His Excellency (H.E.) Dr. Firozuddin Firoz Minister of Public Health; Her Excellency Dr. Najia Tariq, Deputy Minister of Public Health; general directorates of preventive medicine, evaluation, and health information system (EHIS); director of grant and contract management unit (GCMU); Jo Jean Elenes, Acting Office Director, Office of Health and Nutrition, USAID Afghanistan; representatives from basic and essential package of health services; Global Fund (GF), private sector; Japan International Cooperation Agency; the World Health Organization (WHO); academic institutions; and health care staffs.

In total, there were 118 participants (9 female, 109 male) at the conference and 30 posters and 9 presentations were delivered. H.E. Minister of Public Health appreciated this initiative and all TB partners for their valuable achievements and good coordination and collaboration. He noted that, "other health programs should copy this model and present their results to audiences in such a conference." Further, Ms. Jo Jean Elenes, Acting Office Director, Office of Health and Nutrition, USAID Afghanistan, delivered her speech and offered congratulations "over the first ever of such conference." The CTB and NTP developed an action plan as per recommendations and conclusions of the conference. This action plan included among other for CTB to assist NTP to expand DOTS to diabetic centers and screen diabetic patients for TB, and for CTB to expand CB-DOTS to Paktiya and involve community health workers in contact investigation for TB.
The conference was concluded by Dr. Najibullah Safi, the General Directorate of Preventive Medicine. He also expressed congratulations on the launch of this novel conference and added that "other departments and programs must follow this TB model of result conference." He asked that the malaria program "arrange such a conference and avoid the classic way of celebrating of World Malaria Day" on April 14, 2016. He closed the conference with, "I thank USAID and CTB/MSH for conducting such a significant event."

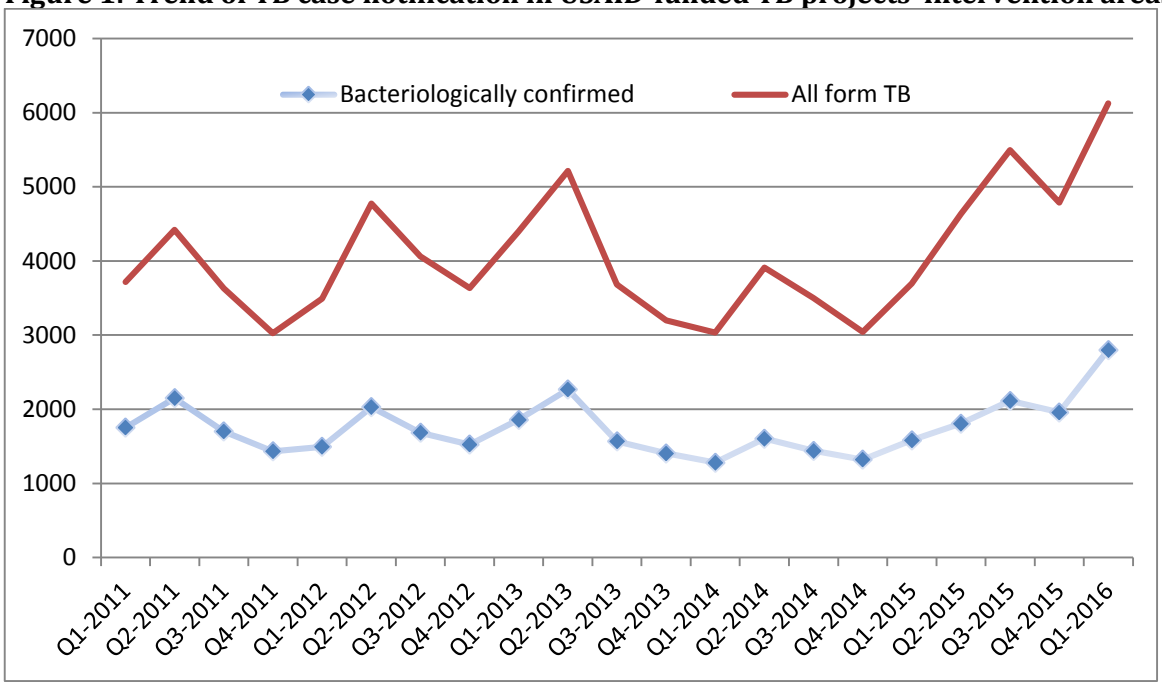
Scene of TB result conference, Suhaila Sediq Conference Hall, Ministry of Public Health, March 27, 2016

1.1.3 CTB contribution to TB case notification and treatment

During 2015, CTB assisted NTP in meeting its strategic objective of finding TB patients. The CTB interventions and strategies resulted in improved TB case notification for both all forms and bacteriologically confirmed TB cases. For instance, between 2015 and 2014, there was a 13% improvement in presumptive TB case identification and examination: a 12% increase in all forms and an 11% increase in bacteriologically confirmed TB case notification. In summary, in CTB intervention areas 24,999 (14,991 female, 11,008 male) TB cases of all forms were notified and 10,652 (6,706 female, 3,949 male) bacteriologically confirmed TB cases were notified, in 2015. Moreover, CTB continued to build on the gains from previous USAID-funded TB projects, TB CAP (Tuberculosis Control Assistance Program) and TB CARE I (a USAID-funded tuberculosis project), and sustained an increase in TB case notification in 2015 (Figure 1).

During Jan–Mar 2016, CTB identified/examined 50,000 presumptive TB patients that were screened for TB and diagnosed 2,800 patients as bacteriologically confirmed and 6,125 patients with all forms of TB. This amounts to approximately a 5% increase compared to the same quarter in 2015.

Figure 1: Trend of TB case notification in USAID-funded TB projects' intervention areas



1.1.4 Enhancement of contact investigation and addressing TB among children

Contact investigation is one of the strategies supported by CTB. This approach resulted in improved access to TB services for children. CTB assisted NTP in conducting training for HCWs on childhood TB diagnosis and treatment, installation of digital X-ray in two children's hospitals, distribution of tuberculin skin tests (TST), and conducting regular supervision and monitoring to children's hospitals.

During 2015, a total of 41,096 (20,543 male, 20,553 female) individuals in contact with a bacteriologically confirmed TB cases were registered and screened for symptoms of active TB. Of these, 7,885 (19%) (3,589 male, 4,296 female) had respiratory symptoms and were tested for TB, 715 (1.7%) (335 male, 378 female) were diagnosed as all forms, and 363 (0.9%) (144 male, 219 female) were diagnosed as bacteriologically confirmed TB cases. Children constituted 7,749 (91%) (3,864 male, 3,885 female) of household contacts; 7,074 (3,536 male, 3,538 female) were put on isoniazid preventive therapy (IPT) and 5,137 (2,523 male, 2,614 female) completed their IPT (Table 1).

Compared to 2014, in 2015 there was a 24% increase in household contacts registered and screened for TB and a 52% increase in household contacts tested for TB, resulting in an overall 50% and 20% increase in diagnosis of TB for all forms and bacteriologically confirmed, respectively. Additionally,

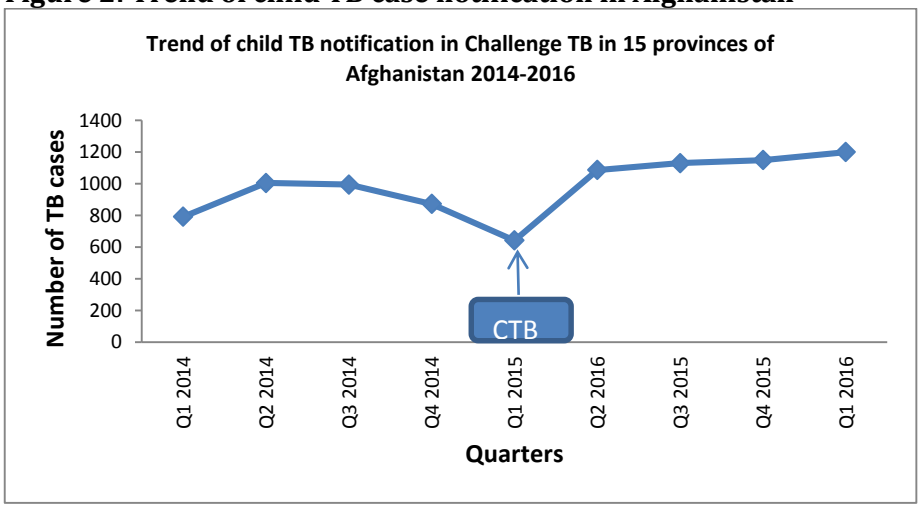
there was 30% increase in identification of children in contact with index TB cases and a 50% improvement in IPT completeness, in 2015 compared to 2014.
In addition, from January–March 2016 11,000 households in contact with index TB cases were registered, demonstrating a 5% increase, compared to previous quarter. Of these 2,000 had respiratory symptoms and were tested for TB, which led to a diagnosis of 200 (10%) cases as all forms and 100 (5%) cases as bacteriologically confirmed TB. In children under the age of five 2,200 cases were identified and put on IPT and 2,000 children completed their treatment (Table 1).

Table 1: Trend of contact investigation and childhood TB in CTB areas (15 provinces) in Afghanistan, 2014-2016

Variable	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Total 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Total 2015	*Difference (%) 2014-2015*	Q1 2016
Household contacts registered	8,035	8,920	8,363	7,903	33,221	9,336	10,404	10,834	10,522	41,096	**24**	**11,000**
Household contacts screened for TB	1,231	1,165	1,331	1,097	4,824	1,848	1,801	1,852	1,844	7,345	**52**	**2000**
All forms TB cases	119	119	131	109	478	161	204	159	191	715	**50**	**200**
Bacteriologically confirmed TB cases	72	78	73	79	302	100	86	97	80	363	**20**	**100**
Estimated no. children under the age of five in contact with index cases	1,533	1,725	2,945	1,589	7,792	1,490	2,136	1,986	2,300	7,912	**2**	**2300**
Children under the age of 5 identified as contacts to index cases	1,272	1,409	1,455	1,450	5,586	1,349	1,914	1,846	2,137	7,246	**30**	**2200**
Children under the age of 5 who were started on IPT	969	774	1,058	966	3,767	1,019	1,559	1,440	1,965	5,983	**59**	**2000**

During CTB, TB diagnosis among children was strengthened, which resulted in a 10% increase in TB case notification among children for all forms (See Figure 2) compared to 2014.

Figure 2: Trend of child TB case notification in Afghanistan



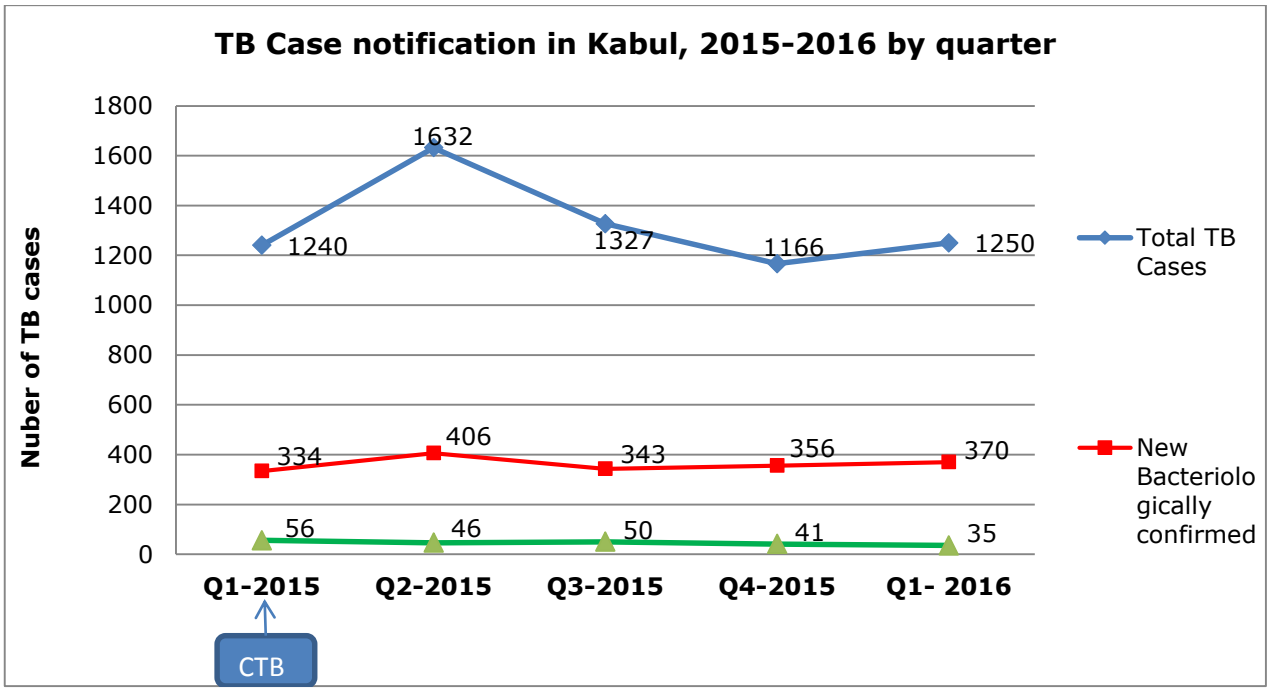
1.1.5 Urban DOTS Implementation

1.1.5.1: Urban DOTS implementation in Kabul

During Jan–Mar 2016, CTB expanded DOTS to additional public and private HFs in the five cities of Herat, Kabul, Kandahar, Jalalabad, and Mazar-I-Sharif. In total, **seven** new public and private HFs engaged in Urban DOTS (two public and five private hospitals). Additionally, **226** health care staff (lab technicians, nurses, and doctors) of the five cities were trained on the standard operating procedures (SOPs) for case detection/diagnosis, treatment, TB infection control, contact investigation and laboratory diagnosis of acid-fast bacilli (AFB). This resulted in improved TB case notification, for example, TB case notification in Kabul for all forms of TB increased by **7%** from **1,166** in the fourth

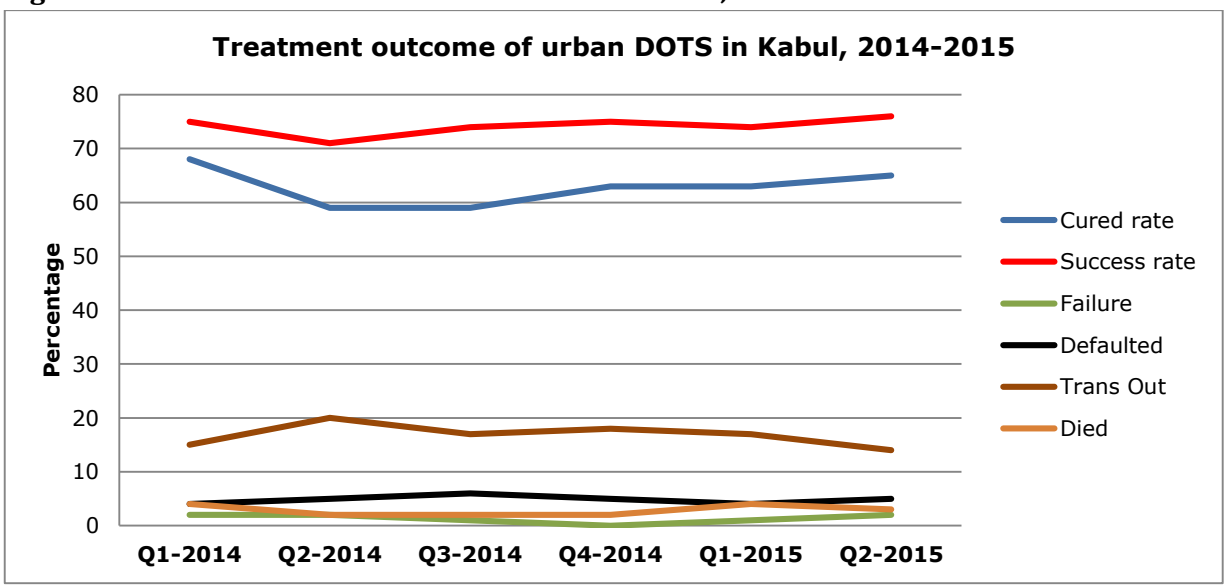
quarter (Q4) 2015 to **1,250** in first quarter of 2016 and new bacteriologically confirmed TB cases increased by 4% from Q4 2015 to Q1 2016 (See Figure 3).

Figure 3: Trend of TB case notification in Kabul, 2015–2016 by quarter



Urban DOTS implementation resulted in improved TB treatment outcomes in Kabul and in the rest of the urban cities. The treatment success rate of four newly covered urban DOTS cities (Kandahar, Herat, Jalalabad, and Mazar-i-Sharif) is 85%. Notably, the treatment success rate of Kabul is 76% and one of the continued challenges for Kabul urban DOTS is the high transfer rate of 14% (Figure 4) compared to the national rate of 5%. CTB has strived to address this challenge by creating strategies to minimize transferring and to improve the cure and treatment success rates. Some of the strategies include engaging in active follow-up of TB patients who initiated their treatment in Kabul and continue treatment in their local provinces, and strengthening the referral system between HFs to report the treatment outcomes of patients who transfer to other locations.

Figure 4: Treatment outcome of urban DOTS in Kabul, 2014-2015



There are two prisons covered by urban DOTS in Kabul—Pul-i-Charkhi and Bagram prisons. Currently, these two prisons provide a full package of TB services. This results in a better treatment outcome for prisoners. For instance, 28 of 30 bacteriologically confirmed TB cases that registered in Pul-i-Charkhi prison of Kabul in Q4 2014, successfully completed their treatment and the overall success rate is 93%, which is higher than national levels (89%). The reason why these rates are higher than national levels is because prisoners stay in prison throughout their treatment period. CTB assisted the NTP with the daily consumption of TB drugs.

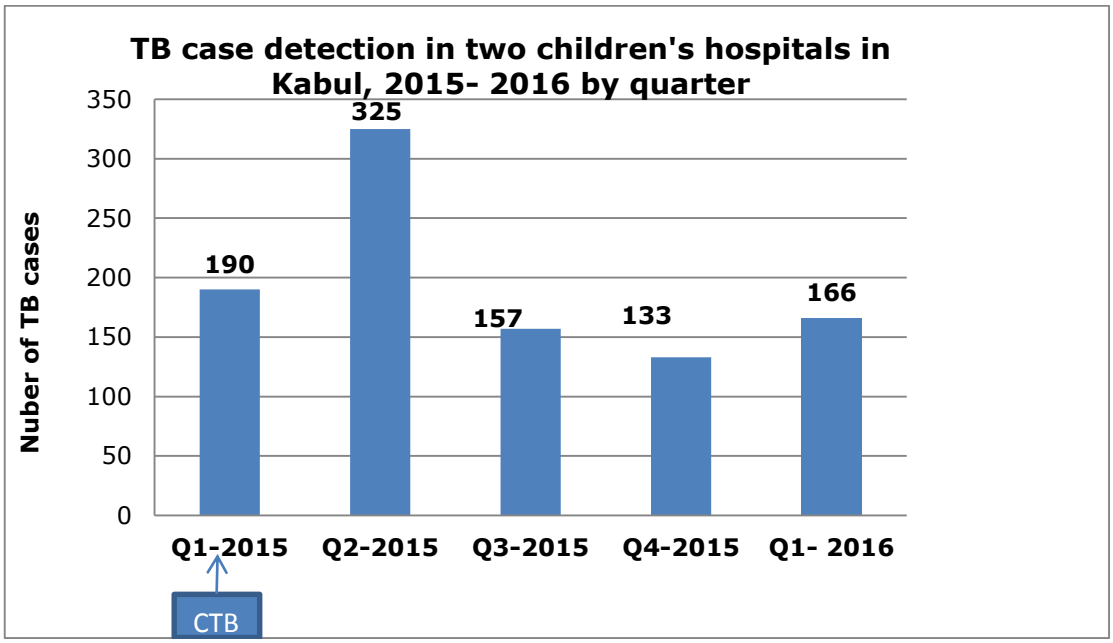
During Q1 2016, two more HFs with lab services engaged in DOTS in Kabul and the number of public and private HFs offering TB services (diagnostic and treatment facilities) increased from 22 in 2009 to 87 in 2016 (cumulative data, Q1 2016) (See Table 2).

Table 2: Health facility coverage in Kabul city, 2009–2016

Indicators/Year	2009	2010	2011	2012	2013	2014	2015	2016-Q1
No. of existing HFs with lab services (public and private)	106	111	111	112	120	131	131	132
No. of HFs covered by DOTS	22	48	53	68	73	80	85	87

During Q1 2016, Kabul urban DOTS expanded active contact screening to other HFs with TB services. In Q1 2016, a total of 1,345 households were screened for TB, 199 of them were examined for AFB, 15 TB cases were detected among contacts, and IPT was initiated for 142 children under age five. Additionally, one children's specialized hospital engaged in TB services by Kabul urban DOTS, and CTB plans to install one digital X-ray machine in this hospital (Figure 5). CTB assisted NTP to conduct training for HCWs, provide supplies and reagents for diagnosis, and improve recording and reporting.

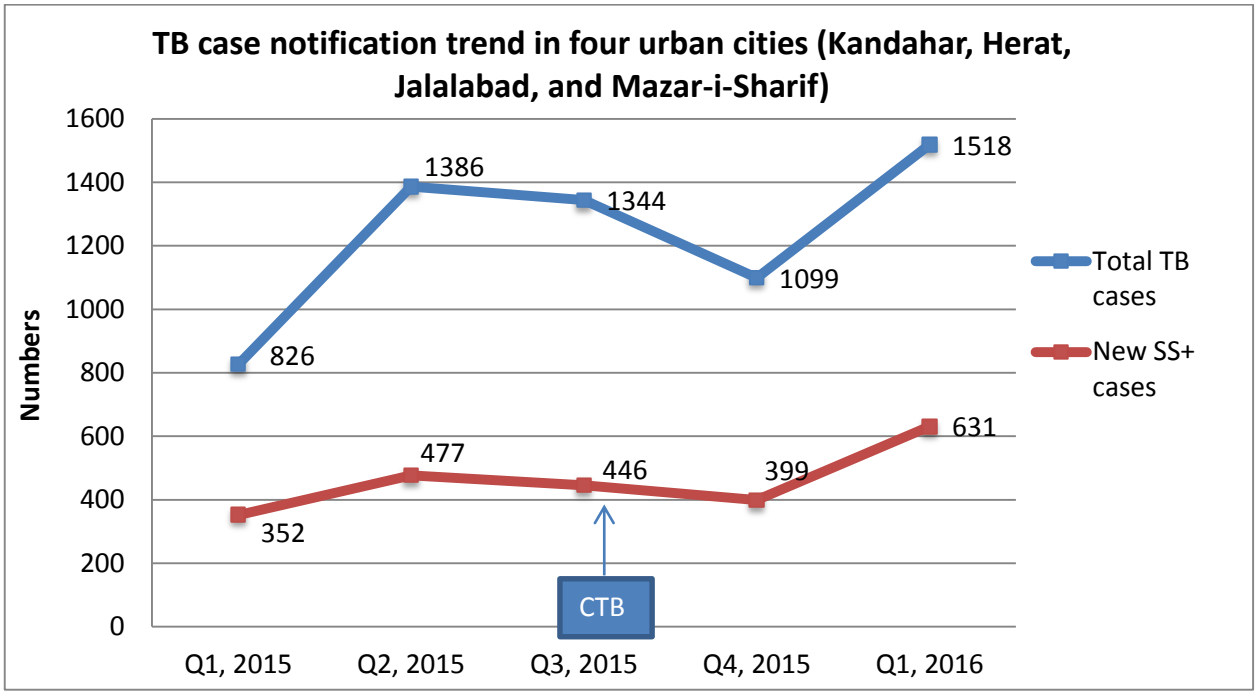
Figure 5: Trend of TB case notification in two children's specialized hospitals in Kabul, 2015–2016 by quarter



1.1.5.2: Urban DOTS implementation in four cities

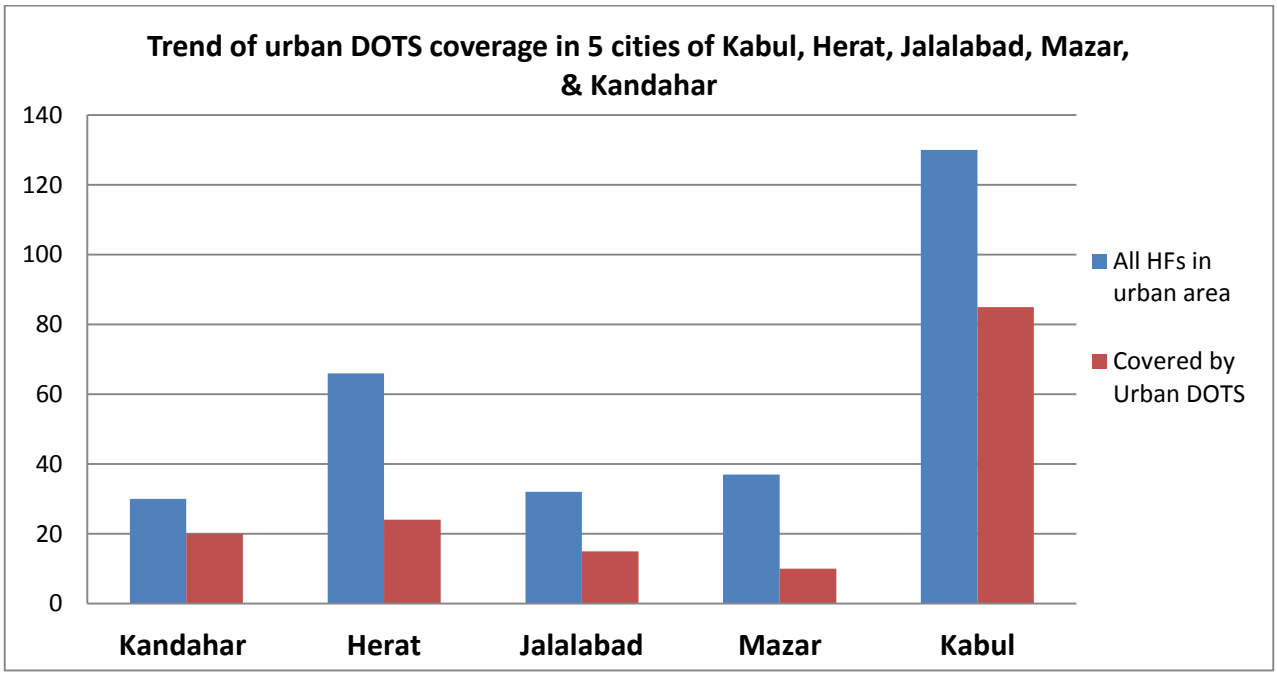
Beyond Kabul, four new urban DOTS cities—Kandahar, Mazar-i-Sharif, Herat, and Jalalabad—dramatically improved TB case detection in Q1 2016. As a result, all forms of TB cases reached 1,518 and new bacteriologically confirmed TB cases reached 631 (Figure 6).

Figure 6: Trend of TB case notification in four urban DOTS cities (Kandahar, Herat, Jalalabad, and Mazar-i-Sharif), 2015–2016 by quarter



The coverage of TB services in five urban DOTS cities increased as expected, and urban DOTS teams committed to cover more HFs and bring TB services closer to the patients (Figure 7). Currently, 69 public and private HFs are providing quality TB services in all four of these cities and in 85 facilities in Kabul city.

Figure 7: Trend of urban DOTS coverage in five urban DOTS cities



During Q1 2016, four new prisons in Kandahar, Herat, Mazar-i-Sharif, and Jalalabad engaged in TB services. A total of 52 TB cases were identified in five prisons and put on treatment (Table 3).

Table 3: Results of DOTS Implementation in five urban cities (Kabul, Jalalabad, Kandahar, Herat, and Mazar-i-Sharif), 2015

	Total TB cases of urban DOTS	Bacteriologically confirmed TB cases	Total TB cases by private	Bacteriologically confirmed TB cases by private	TB cases in prisons
Kabul	1,250	370	171	37	34
Kandahar	366	121	80	37	9
Jalalabad	386	152	70	25	3
Herat	403	185	58	29	2
Mazar	363	173	40	9	4
Total	**2,768**	**1,001**	**419**	**137**	**52**

During this quarter, an active contact screening strategy was expanded to five urban DOTS provinces—Kabul, Herat, Kandahar, Nangarhar, and Balkh—and HCWs began the activities related to the strategy. During the reporting period among 1,435 index cases in five provinces, 6,305 household contacts were screened and 378 were identified as presumptive TB patients. Of these, 30 patients were notified as confirmed TB cases and put on TB treatment. In addition 1,824 children under age five were put on IPT.

In summary, during Jan–Mar 2016, urban DOTS implementation in Kabul, Herat, Kandahar, Jalalabad, and Mazar-i-Sharif resulted in the identification and examination of **14,327** presumptive TB patients, the detection of **1,010** bacteriologically confirmed pulmonary TB cases, and **2,778** cases with all forms TB. Urban DOTS implementation resulted in improved TB case notification and contributed to 58% of TB cases at CTB intervention areas. Additionally, the private section contribution improved from 7.7% in the previous quarter to 11.6% in Jan–Mar 2016, and the prison contribution reached 1.8%, compared to 1.3% in the previous quarter (Table 14).

1.1.6 Community-based DOTS implementation

As per assumptions, a large portion of missed TB cases lie in rural areas and presumptive TB patients who live in these areas rarely visit diagnostic centers. To address this challenge, CTB assisted NTP to expand community-based DOTS (CB-DOTS) to these areas. During this quarter, CTB assisted the NTP to implement CB-DOTS in 14 provinces through sub-contracts with primary health care-implementing non-governmental organizations (NGOs). Last quarter, CTB conducted an orientation workshop for 38 participants; the participants were communicable diseases officers, central/provincial CB-DOTS focal persons, and NTP staffs. CB-DOTS was conducted in 42 provincial TB task force meetings in 14 provinces. Gaps such as low TB case notification from the previous month were identified and an action plan was developed to address these gaps, which will be followed up at the next month's task force meetings.

Since November 2015, the CB-DOTS project oriented 593 HF staffs on the CB-DOTS scope of work and on the recording and reporting of overall TB and CB-DOTS performance outcomes. Additionally, the CB-DOTS project trained 547 (527 male, 15 female) community health supervisors and 11,348 (6129 male, 5448 female) CHWs on TB and CB-DOTS approaches. In addition, CTB and NTP assisted DOTS implementing organizations in conducting 170 community awareness events in 14 provinces.

Furthermore, CB-DOTS technical officers from implementing NGOs conducted 195 supervisory visits at HF levels and 110 visits to health post levels. Community health supervisors supervised 760 health posts in 14 provinces and implementing organizations conducted 402 CHW monthly meeting sessions at the HF level. CTB provided assistance to CHWs to implement CB-DOTS effectively and efficiently. CB-DOTS implementation was evaluated, feedback was provided, and action plans were developed to address gaps like low performance of CHWs and recording and reporting of CB-DOTS performance at the HF level. CTB will follow up on the action plan implementation.

The 42 best performing health workers, who referred a large number of presumptive TB patients for diagnosis, were rewarded. This included CHWs, community members, laboratory technicians, nurses, and doctors.

CTB mobilized and organized cured TB patients under CB-DOTS and established 65 cured TB patients' councils (shuras) in 14 provinces, who meet once a quarter. The cured patient councils assist with TB cases findings, provide TB education to reduce stigma, promote community assistance and awareness, and encourage TB patients to adhere to their treatment.

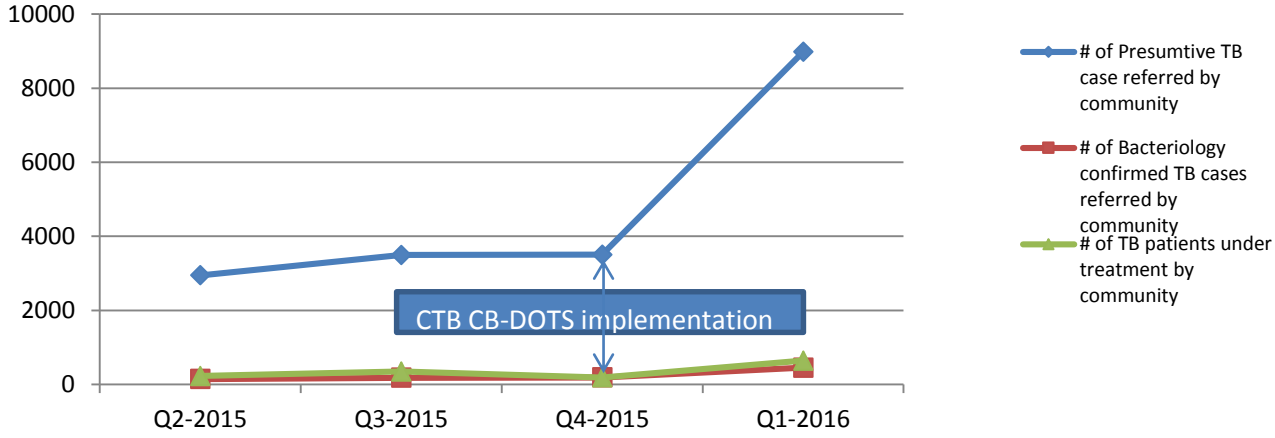
In brief, CB-DOTS was implemented in 526 HFs in 14 provinces, resulting in the identification of 8,977 presumptive TB patients, who were referred to HFs for diagnosis. Of them, 456 (5%) were diagnosed as bacteriologically confirmed pulmonary TB and 689 all form TB cases. CHWs have been providing daily treatment to 644 TB patients in their villages (See Table 4).

Table 4: Community-based DOTS outcomes, first quarter of 2016

Indicator	Presumptive TB cases by community	Bacteriologically confirmed TB cases by community	All TB cases by community	# of contact screened by community	# of children under five started on IPT	# of TB patients started on treatment (DOT) by community	Cure rate	Success rate
Performance this quarter	8,977	456	689	1,521	1,103	644	N/A	N/A

After a long delay in CB-DOTS implementation due to administrative issues (e.g. vetting process), in October and November 2015 contracts were finally signed with eight local NGOs in 14 provinces (Badakhshan, Baghlan, Balkh, Bamyan, Faryab, Ghazni, Herat, Jowzjan, Kabul, Kandahar, Khust, Nangarhar, and Takhar). CB-DOTS implementation through these local NGOs resulted in an improvement in TB indicators in the aforementioned provinces; the presumptive TB cases referred by community increased from 2,946 in the second quarter (Q2) of 2015 to 8,977 in Q1 2016 (300% improvement). The number of bacteriologically confirmed TB cases referred by community increased from 149 in Q2 2015 to 456 in Q1 2016 (300% improvement). Similarly, the number of TB patients under treatment by community increased from 232 in Q2 2015 to 644 in Q1 2016 (278 improvement) (See Figure 8).

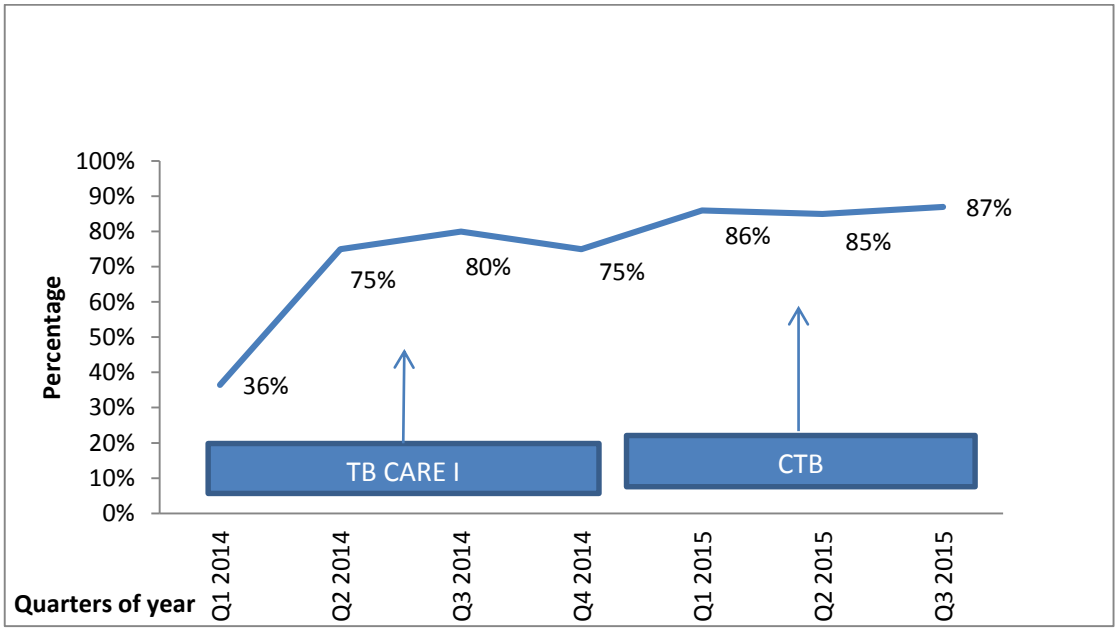
Figure 8: Trend of CB-DOTS outcome indicators in 14 provinces, Q2 2015 to Q1 2016



1.1.7 Monitoring and Evaluation (M&E), Surveillance, and Research

The TB surveillance system was further developed and the electronic reporting system enhanced. Completeness and timeliness of TB data increased from 36.4% during the first two quarters of 2014 to 87% (Figure 9), and 96% of facilities reported completion of five data sets that met deadlines. In brief, 91% of facilities submitted TB case registration, 89% submitted presumptive TB reports, 84% reported sputum smear conversions, and 76% submitted contact investigation reports. In addition, TB surveillance sensitivity for presumptive TB case notification improved from 51% in 2013 to 70% in 2015 ($p < 0.0000001$, odds ratio 2.2) (Table 4). TB program surveillance strengthening initiatives through developing partnerships resulted in improved completeness and timeliness of TB data and improved sensitivity of TB surveillance. Thus, CTB will be further enhancing electronic reporting of TB data.

Figure 9: TB data completeness and timeliness, 2014–2015



The TB surveillance system strengthening and overall CTB health system strengthening initiatives led to increased TB surveillance system sensitivity, with 70% of presumptive TB patients identified and tested for TB (Table 5).

Table 5: Trend of TB surveillance sensitivity, 2013–2015

	Estimated presumptive TB patients reported by Health Management Information System	Presumptive TB patients registered and tested for sputum microscopy	Sensitivity*
2013	408,350	208,153	51%
2014	408,350	256,416	63%
2015	408,350	286,099	70%

*Sensitivity= presumptive TB cases tested for TB/presumptive TB cases reported by HMIS unit of MOPH.

Operations research

In addition, the CTB team assisted the NTP to develop and submit 17 abstracts for the upcoming 47th World Conference on TB and Lung Health to be held in Liverpool. The aim was to document the best performances, provide answers to basic questions regarding TB, and evaluate various aspects of the TB program. For example, CTB assisted NTP in evaluating the CB-DOTS approach. The data from HFs in 14 provinces was collected and data from 20,168 presumptive TB patients and 3,221 TB cases was reviewed. Of these, 2,123 (10.5%) presumptive TB patients were referred by CHWs and community volunteers and 122 (6%) of them were diagnosed as bacteriologically confirmed TB cases. This rate was 4.8% among presumptive TB patients identified by HCWs (p-value of 0.0003) (Table 6). Data reviewed from 3,221 TB cases showed that CHWs provided daily TB treatment to 214 (6%) bacteriologically confirmed TB cases and 202 (94%) of them successfully completed their treatment; the national treatment success rate was 89% in 2014 (p-value 0.008). Further, failure, default, and transfer out rates for those under DOT by CHWs were 0%, 3%, and 1%, respectively. For those under DOT at HFs, these rates were 1%, 2%, and 5%, respectively. It can be concluded that CB-DOTS contributed to the overall identification and referral of presumptive TB patients and improved adherence to TB treatment.

Table 6: Contribution of CB-DOTS on TB case notification and treatment of TB patients

Variable	Contribution of CHWs	Contribution of HFs	Remarks
Presumptive TB patients	2,123 (10.5%)	18,487	
Bacteriologically confirmed TB cases	122 (6%)	860 (4.8%)	p-value 0.0003
Treatment success rate	(202)94%	89% (national value 2014)	p-value 0.008
Failure rate	0%	1%	
Default rate	3%	2%	
Transfer out rate	1%	5%	

1.1.7 TB Infection Control

Between January and March 2016, CTB assisted NTP to assess 15 HFs for airborne infection control, primarily TB infection control (TBIC) in 10 out of 15 provinces. Their redesign plan was developed to consider airborne isolation (adequate air disinfection ≥ 12 air changes per hour, with some efforts to keep air within the rooms, as well as maintaining simple negative pressure in rooms). Meanwhile, 15 TBIC committees were established to organize, implement, and monitor and evaluate implementation

of TBIC measures. CTB also assisted NTP in conducting on-the-job training for 74 health care staff from Kandahar, Jauzjan, and Takhar provinces to assist frontline health care staffs with implementing TBIC measures and TBIC standards. During the training, health care staff went to DOTS excellence centers to assess the structural design of high-risk areas, patient flow, case-finding processes, as well as recording and reporting with the intention of copying best practices. Finally, CTB helped NTP develop 12 job aid posters on TBIC (patient flow, triaging for TB presumptive patients, airborne and droplet precautions, usage and installation of ultraviolet germicidal irradiation, TBIC plan, and committee terms of reference) and laboratory logistics (laboratory design, Ziehl-Neelsen method, flow chart on TB microscopy, microscopes parts, and waste management); 12,000 copies will be printed and disseminated to 34 province HFs.

The implementation of TBIC was assessed to explore the level of knowledge of HCWs on TBIC measures in 15 CTB-supported provinces. Between Jan–Feb 2016, the CTB assisted NTP in conducting a cross-sectional baseline evaluation of HCWs' knowledge, attitudes, and practices of TBIC and hand hygiene (HH). In total, 230 (40% nurses, 35% physicians, and 25% laboratory technicians) study subjects were interviewed from 80 HFs in 15 provinces; 70% of the participants were male and 30% female.

A standardized questionnaire was administered to HCWs (nurses, laboratory technicians, and physicians). Knowledge items were scored as correct/incorrect. Attitude and practice items were rated with five- and three-point rating scales.

Descriptive statistics were used to assess responses. The study found that 44% of HCWs did not believe HH was necessary before patient contact. Only 7% of HCWs reported regularly performing HH prior to patient contact while 49% reported performing HH after patient contact. Seventy-six percent of responders reported that barriers to HH included lack of soap and running water (Table7).

TBIC knowledge was excellent among HCWs with 90% of HCWs correctly describing TBIC procedures. Among study participants, 91% of HCWs agreed they were at high risk of acquiring TB from patients, 92% believed that TBIC can prevent TB transmission within their hospitals, and 95% believed that TBIC is important to protect patients. Notably, only 15% of HCWs regularly wore respirators when caring for TB patients.

Limited access to masks and poor design of HF buildings to isolate infectious TB patients and maximize ventilation were the only limitations against TBIC implementation noted at the HFs studied. Of note, half of HCWs felt UV lights may be harmful. Based on the data, it can be concluded that increased awareness among HCWs about the importance and proper practices of HH, along with improving access to antiseptic hand soap, may help improve patient safety. Additionally, improved infrastructure is needed to enhance TBIC and allay HCW concerns of acquiring TB in hospitals. CTB is going to provide technical assistance to HCWs through trainings and to the NTP and the ministry of public health on (re)designing health care settinsg to ensure TB infection control measure application.

Table 7: Exploring level of knowledge of HCWs on TBIC and Hand Hygiene (HH) in 15 provinces

Variables	Variables status
Number of HFs studied	80
Number of HCWs surveyed	230 (nurses 40%, physicians 35%, lab technicians 25%)
HCWs did not believe that HH is necessary before patient contact	44%
HCWs regularly performed HH prior to patient contact	7%
HCWs performed HH after patient contact	49%
Barriers to HH were lack of soap and running water	76%
Knowledge on TBIC among HCWs	>90%
HCWs agreed they were at high risk of acquiring TB from patients	71%

HCWs agreed TBIC can prevent TB transmission within their hospital	92%
HCWs agreed TBIC is important to protect patients	95%
HCWs regularly wore respirator masks in high-risk settings	15%
HCWs felt UV lights may be harmful	50%
Limitation to TBIC implementation	Poor design of HFs to isolate infectious TB patients and maximize natural ventilation

Summary milestone data as of March 2016

Total # of milestones expected by Q2 (cumulative for Oct 15 - Mar 16)	Milestones **met** by Q2 (cumulative for Oct 15 - Mar 16)		Milestones **partially met** by Q2 (cumulative for Oct 15 - Mar 16)		Milestones **not met** by Q2 (cumulative for Oct 15 - Mar 16)	
N	#	%	#	%	#	%
40	20	50	10	25	10	25

2. Year 2 Activity Progress

Table 8: Sub-objective 1. Enabling environment								
Planned Key Activities for the Current Year	Activity #	Planned Milestones				Milestone Status	Milestone met? (Met, partially met, not met)	Remarks *(reason for not meeting milestone, actions to address challenges, etc.)*
		Oct–Dec 2015	Jan–Mar 2016	Apr–Jun 2016	Year End	Oct-2015–Mar 2016		
To sign subcontracts for CB-DOTS implementation with 9 NGOs in 15 provinces	1.1.1	9 NGOs/15 provinces	9 NGOs/15 provinces	9 NGOs/15 provinces	9 NGOs/15 provinces	8 NGOs/14 provinces	Partially met	CTB will use alternative approach to cover this provinces and will implement it through CTB/MSH
To conduct CB-DOTS taskforce meeting at central level	1.1.1	1 meeting/9 NGOs/15 provinces	1 meeting/9 NGOs/15 provinces	1 meeting/9 NGOs/15 provinces	1 meeting/9 NGOs/15 provinces	1 meeting/8 NGOs/14 provinces. In total two meetings conducted and 35 (33 male and 2 female) NGO, NTP and CTB staffs attended	Met	
To conduct CB-DOTS taskforce meeting	1.4.1	45 meetings in 15 provinces	45 meetings in 15 provinces	45 meetings in 15 provinces	45 meetings in 15 provinces	72 meetings in 14 provinces	Met	

To conduct visits and monitoring to HFs to monitor the implementation of CB-DOTS	1.4.2	10 visits to 10 provinces and visit 4 HFs and two health posts in each visit	10 visits to 10 provinces and visit 4 HFs and two health posts in each visit	10 visits to 10 provinces and visit 4 HFs and two health posts in each visit	10 visits to 10 provinces and visit 4 HFs and two health posts in each visit	17 visits to 10 provinces and visited 4 HFs and two health posts in each visit	Met	
To conduct an annual coordination workshop	1.4.3		One event with 55 participants			Workshop conducted and 38 (36 male and 2 female) individuals from NGOs, NTP, CBHC and GCMU of MOPH attended this event	Met	

Table 9: Sub-objective 3. Patient-centered care and treatment

Planned Key Activities for the Current Year	Activity #	Planned Milestones				Milestone Status	Milestone met? (Met, partially met, not met)	Remarks *(reason for not meeting milestone, actions to address challenges, etc.)*
		Oct–Dec 2015	Jan–Mar 2016	Apr–Jun 2016	Year End	Oct 2015–Mar 2016		
To conduct a strengthening coordination workshop between the public and private health sectors in five cities—Kabul, Mazar, Herat, Kandahar, and Jalalabad—with 60 individuals from different stakeholders	**3.1.1**	Workshop for 75 participants	Workshop for 75 participants	Workshop for 75 participants	Workshop for 75 participants	Strengthening coordination workshop between public–private health sectors conducted in Kabul, Herat and Jalalabad for more than **454** representatives	Partially met	

in each city To engage private practitioners (PP) in TB services in five cities, 20 PPs in each province, and, in total, 100 PPs will engage in TB services in Kabul, Mazar, Herat, Kandahar, and Jalalabad cities To install two digital X-ray machines in urban-DOTS cities		 Two digital X-ray machine procured (procurement report)	Training for 50 participants	Training for 50 participants		CTB has set up urban DOTS in five cities and will engaged PPs in next quarter The purchase order for two digital X-ray machines is in pipeline and room setups for two other machines that were purchased during first year are in progress		Rescheduled for Quarter 3 The procurement of two digital X-rays machines of year 1 has completed and arrived to the country. And X-ray room set up is in process and will be completed next quarter
To conduct an assessment of 30 new public and private HFs in Kabul, Mazar, Herat, Kandahar, and Jalalabad cities To expand TB services to 30 public and private HFs in these five cities	**3.1.2**	8 HFs assisted TB services expanded to 8 HFs	8 HFs assisted TB services expanded to 8 HFs	8 HFs assisted TB services expanded to 8 HFs	6 HFs assisted TB services expanded to 6 HFs	Assessment of **8** private HFs completed DOTS expanded to **17** new public and private HFs during Oct 2015-Mar 2016 in five cities of Kabul, Kandahar, Herat , Mazar and Jalalabad	Met	

Initial and refresher training for health care staff	**3.1.3**	Training for 110 health care staffs	Training for 110 health care staffs	Training for 110 health care staffs	Training for 110 health care staffs	SOP training conducted for 226 (32 female, 194 male) HCWs in 5 urban DOTS cities of Kabul, Jalalabad, Kandahar, Herat and Mazar	Met	
To establish five technical panel reviews of specialists in each city to support the identification of TB in child, complicated, and extrapulmonary TB cases in Kabul, Mazar, Herat, Kandahar, and Jalalabad STTA to develop SOPs for diagnosis and treatment of extrapulmonary TB cases	**3.1.4**	1 technical panel Short-term technical assistance (STTA) report and draft SOPs	1 technical panel	1 technical panel	1 technical panel	2 technical panels review established in Kabul Draft of SOP for extrapulmonary TB developed and is in its final stage and will be finalized in May 2016	Partially met	The establishment of technical panel review will take place after the finalization of extra pulmonary TB SOPs
To conduct TB awareness campaigns for 4,000 students and community members in Kabul, Mazar, Herat, Kandahar, and Jalalabad cities Broadcasting TB	**3.1.5**	800 individuals attended awareness events 15 TB	800 individuals attended awareness events 15 TB	800 individuals attended awareness events 15 TB	800 individuals attended awareness events 15 TB	TB awareness events conducted in 5 cities and more than 970 individuals attended in Kabul, Herat, Kandahar and Jalalabad TB messages	Met	

messages by local radios and TVs		messages aired by local media	messages aired by local media	messages aired by local media	messages aired by local media	broadcasted by local media		
To support the laboratory network system in five urban DOTS cities by providing microscope spare parts	**3.2.1**	Spare parts for 14 microscopes	Spare parts for 12 microscopes	Spare parts for 12 microscopes	Spare parts for 12 microscopes		Not met	Baseline assessment conducted; procurement of microscope parts is in progress and will be completed in May 2016
To establish a monthly provincial task force meeting in selected cities (12 TB task force meetings will be conducted in each city) To conduct coordination meetings with different stakeholders in five urban DOTs cities	**3.2.2**	15 task force meetings 15 coordination meetings in 5 cities	15 task force meetings 15 coordination meetings in 5 cities	15 task force meetings 15 coordination meetings in 5 cities	15 task force meetings 15 coordination meetings in 5 cities	12 task force meetings conducted during the quarter in the 4 cities of Kabul, Kandahar, Jalalabad and Herat 20 coordination meeting conducted in 5 cities (Kabul, Herat, Mazar, Kandahar, and Jalalabad)	Partially met	
To conduct orientation workshops for HCWs and health volunteers in Herat, Mazar, Kandahar, and Jalalabad	**3.2.3**	170 volunteers attended events	170 volunteers attended events	170 volunteers attended events	170 volunteers attended events	First batch of orientations conducted for 180 (73 female and 107 male)volunteers of Herat Afghan Red Crescent Society (ARCS)	Met	
To conduct quarterly review meetings for urban DOTS HFs (private HFs and NGO	**3.2.4**	200 HCWs attended in 5 cities	200 HCWs attended in 5 cities	200 HCWs attended in 5 cities	200 HCWs attended in 5 cities	Quarterly review meeting conducted in 5 cities of Kabul, Mazar, Herat,	Met	

HFs) that are not covered by GF budget during the four quarters of the year, and, in total, 20 QRW in five cities (Kabul, Mazar, Herat, Kandahar, and Jalalabad) To conduct a 1-day quarterly review workshop (QRW) for 40 private practitioners and referral centers in Kabul city						Kandahar and Jalalabad implementing urban DOTS and more than 272 health workers participated		Quarterly review for referral HFs will start in Quarter 3
To conduct 200 supervisory visits to 140 HFs by quarter in the 5 cities of Kabul, Mazar, Herat, Kandahar, and Jalalabad	**3.2.4**	50 visits in all 5 cities conducted	50 visits in all 5 cities conducted	50 visits in all 5 cities conducted	50 visits in all 5 cities conducted	61 visits conducted at HFs in 5 cities Kabul, Mazar, Herat Kandahar and Jalalabad and 153 total HFs covered	Met	
To conduct active contact investigation of 4,000 index TB patients in 5 urban cities	**3.2.4**	1,000 index cases screened	1,000 index cases screened	1,000 index cases screened	1,000 index cases screened	801 index TB cases screened in 5 provinces of Kabul, Nangarhar, Herat, Kandahar, and Balkh	Partially met	The urban DOTS implementation in Balkh province was delayed till Feb 2016, thus, the target was not 100% achieved

To establish a standardized recording and reporting system in urban HFs, 126 public and private HFs will report to NTP quarterly base using NTP data collection formats	**3.2.5**	126 HFs reporting TB data	126 HFs reporting TB data	126 HFs reporting TB data	126 HFs reporting TB data	Reports submitted from 126 HFs	Met	
To engage two additional children's specialized hospitals in the management of TB in children (child SOP training for three days/60 HCWs and 10 facilitators) To engage two new diabetic centers in TB services in Kabul and Mazar-i-Sharif to screen diabetic patients for active TB and strengthen the referral system To conduct a 15-day STTA on assessing TB and diabetes situation analysis and developing TB and diabetes SOPs for case detection and treatment	**3.1.1**	STTA report and draft SOP	2 hospitals engaged	One diabetic centers engaged in TB		Ataturk specialized hospital engaged in DOTS in Kabul and two children wards in Mazar and Herat city covered by DOTS and digital X-ray machine will be installed there. One additional diabetic center engaged in the TB program in Kabul	Met	The STTA for TB/diabetes is under negotiation with NTP and home office and planned for next quarter

To conduct active case finding in internally displaced person (IDP) camps and TB among diabetes	**3.1.2**	5 IDP camps screened for TB	5 IDP camps screened for TB	5 IDP camps screened for TB	5 IDP camps screened for TB	Assessment in camps to do situation analysis were carried out in Jalalabad and Herat cities	Partially met	This activity will be conducted jointly with the GF/United Nations Development Program (UNDP); GF has not started the activity (**GF delayed)**
To conduct orientation session for voluntary confidential counseling and testing staff in five cities	**3.1.1**		2 batches of training for 20 participants	2 batches of training for 20 participants	2 batches of training for 10 participants			This activity will be conducted in quarter 3 according to request of HIV department

Table 10: Sub-objective 7. Political commitment and leadership

Planned Key Activities for the Current Year	Activity #	Planned Milestones				Milestone Status	Milestone met? (Met, partially met, not met)	Remarks *(reason for not meeting milestone, actions to address challenges, etc.)*
		Oct–Dec 2015	Jan–Mar 2016	Apr–Jun 2016	Year end	Jan–Mar 2016		
To coordinate CB-DOTS activities with basic package of health services (BPHS)-implementing NGOs to gain their commitment to DOTS	7.2.1	1 event per quarter	1 event per quarter	1 event per quarter	1 event per quarter	One event conducted in Kabul in Feb 2016. In total 38 (36 male, 2 female) individuals from NTP, CTB, the **Grants and Service Contracts Management Unit**/Ministry of Public Health (MOPH), community based health care (CBHC)/MOPH, and NGOs participated. The CB-DOTS implementation was reviewed and	Met	

						feedback was provided.		
Cost sharing by private sector	7.2.3		10 HFs supplied with equipment	10 HFs supplied with equipment	10 HFs supplied with equipment	10 HFs covered by DOTSs in five cities such as Kabul, Mazar, Herat, Kandahar and Jalabad	Met	
Cost sharing by private sector	7.2.4	Provision of TB services for each month for one year	Provision of TB services each month for a year	Provision of TB services each month for a year	Provision of TB services each month for a year	51 private HFs covered by urban DOTS in five cities. Each HF dedicated one room for DOTS and one staff (part time). The cost of each room is estimated at $100 per month. The total estimated cost share during Jan–Mar would be $10,300 and the staff time estimated charge is $200 per facility, totaling $30,600 this quarter.	Met	
Cost sharing by provincial health office (PHO) and NGO	7.2.5	15	15	15	15 (total 60 visits supported)	The PHOs of Nangerhar, Herat, Balkh, and Kandahar provided an office for CTB consultants. This quarter 4*3 months (12 months total) were provided by PHOs. The estimated cost of the office is 12*$200=$2,400 USD. Also, two local	Partially met	

						consultants located in NTP and it will be an estimated 2*3*$100=$600 USD. PHO provided transportation to CTB staff to attend World TB Day celebration in three provinces of Khost, Paktika, and Jowzjan, for an estimated cost of $250.		
Support the NTP to conduct the annual national evaluation workshop	7.3.1			100 participants attended this event			N/A	
Workshop on political commitment to DOTS	7.3.2		25 participants	30 participants	55 participants in a year	CTB has developed the NTP core function and planned to implement in next quarter	Not Met	
Cost sharing by private sector	7.3.3		Cost sharing tool applied at 20 HFs	Cost sharing tool applied at 10 HFs			Not Met	
NTP leadership competency	7.3.4	15 staff from NTP attended/applied core function tool	20 staff from NTP attended/applied core function tool	20 staff from NTP attended/ applied core function tool		Tool shared with NTP and planned to apply next quarter	Partially met	NTP core functions tool will be applied beginning of Q3

Table 11: TB infection control

Sub-objective 5. Infection control								
Planned Key Activities for the Current Year	Activity #	Planned Milestones				Milestone Status	Milestone met? (Met, partially met, not met)	Remarks *(reason for not meeting milestone, actions to address challenges, etc.)*
		Oct–Dec 2015	Jan–Mar 2016	Apr–Jun 2016	Year End	Oct 2015-Jan–March 2016		
Assist NTP to select 30 HFs for TBIC expansion and implementation in 15 CTB provinces	5.1.1	10 facilities assessed	10 facilities assessed	10 facilities assessed	30 total facilities assessed	30 facilities assessed in districts of Jalalabad, Goshta, Khogiani, Kama, Kandahar, Spinboldak, Zherai, Kabul, Charasiab, and Qarabagh	Met	Selection criteria: that facilities with higher risk of infection and workload such as district and provincial hospitals and some CHCs, easily accessible health facilities
Assist the NTP to establish TBIC committee in assessed 30 HFs	5.1.2	10 TBIC committees established, 75 meetings conducted	10 TBIC committees established, 75 meetings conducted	10 TBIC committees established, 75 meetings conducted	75 meetings conducted Total conducted during the year: 300	30 TBIC committees established in 13 province and 75 meetings conducted by TBIC committees at HFs. The members are health care staff. The committees reviewed the planned activities and intend to implement TBIC measures to identify presumptive TB cases and diagnose them as quickly as possible. In Kandahar, it resulted in a 23% increase in TB case notifications	Met	Terms of reference for TBIC committees: develop and implement TB infection control measures, conduct regular committee meetings, and monitor the implementation of TBIC

						this quarter compared to the same quarter in 2014.		
To develop TB infection prevention and laboratory biosafety job aid (pocket guide for professional health care providers)	5.1.3		3,000 copies of pocket guide developed and disseminated				Not met	The pocket guide drafted and sent to NTP for review and approval. It will be printed and disseminated in Jun 2016
To conduct training on airborne precaution standards (which will be incorporated into the design of any construction/ renovation) and to conduct on-the-job training on TBIC control strategies	5.1.4	50 staff attended the orientation sessions, 100 HCWs attended on-the-job training	50 staff attended the orientation sessions, 100 HCWs attended on-the-job training		100 attendees, 200 HCWs	50 staff attended the orientation sessions, 100 HCW attended on-the-job training in five cities of Kandahar, Baghlan, Jalalabad, Jowzjan and Faryab	Met	Staff trained through this training are health care staff from TBIC committees
Assist the NTP to consider airborne precaution measures in HFs' high-risk areas and to assist the NTP to redesign and install mechanical ventilation equipment in the laboratories in 15 provinces	5.1.5	10 assessments conducted, 10 HFs renovated from system enhancing for health actions in transition	10 assessments conducted, 10 HFs renovated from SEHAT/BPHS project	10 assessments conducted, 10 HFs renovated from SEHAT/BPHS project	30 assessments, 30 facilities redesigned	10 HF assessments were conducted and technical assistance (local) was provided to BPHS/SEHAT to renovate HFs	Met	Under year two, CTB provides technical assistance to private sector to redesign HFs for TBIC only in urban DOTS facilities in five provinces

		(SEHA)/BPHS project						
Redesign HFs for TBIC	5.2.1	10 HFs renovated from SEHAT/BPHS project	10 HFs renovated from SEHAT/BPHS project	10 HFs renovated from SEHAT/BPHS project	30 renovations	30 HFs assessed and provided TA to implementing organization to renovated	Not met	TA provided to BPHS to redesign, renovate HFs according to the assessment findings, but they did not complete this renovation due to lack of budget in BPHS work plan; CTB will continue discussions with MOPH
Conduct surveillance of TB among HCWs	5.2.2		600 HCW assessed for active TB			CTB started the protocol development and completed literature review and will finalized the protocol and start field work in May 2016	Not met	

Table 12: Sub-objective 10. Quality data, surveillance and M&E

Planned Key Activities for the Current Year	Activity #	Planned Milestones				Milestone Status	Milestone met? (Met, partially met, not met)	Remarks *(reason for not meeting milestone, actions to address challenges, etc.)*
		Oct–Dec 2015	Jan–Mar 2016	Apr–Jun 2016	Year End	Oct 2015–Mar 2016		
TB electronic reporting system (TBIS)	10.1.1		Revised database			The TB recording and reporting forms revised and its translation is under process.	Not Met	Postponed to Q3
TBIS training	10.1.2		60 staff trained	60 staff trained	120 staff trained		Not Met	Postponed to Q3

Monitor electronic reporting	10.1.3	16 visits	16 visit	16 visits	16 visits (64 visits)	4 visits	Partially met	This quarter, the NTP conducted remote assistance to provinces to monitor the TBIS implementation. During Q2, the team visited the provinces with poor performance. The focus was on feedback provision and revision of NTP guidelines, including reporting formats.
TB data quality assessment	10.1.4			Assessment protocol and final report		Protocol drafted and field work will be conducted next quarter	N/A	
To support quarterly review workshops and supervision to HFs	10.1.5	15 quarterly review workshops held	15 quarterly review workshops held	15 quarterly review workshops held	15 quarterly review workshops held	13 quarterly review workshops held in 13 provinces in Jan 2016	Met	
Epidemiological assessment	10.2.1					Assessment report	Not Met	
Publish and disseminate operations research	10.2.4	Final draft of 3 papers				One paper drafted and two are under process	Partially Met	
Operations research funding provided by local partner	10.2.5		Research protocol and report			Expression of interests drafted and shared through ACBAR site	Not met	

3. Challenge TB's Support to Global Fund Implementation in Year 2

Current Global Fund TB Grants

Name of grant & principal recipient *(i.e., TB NFM - MoH)*	**Average Rating***	**Current Rating**	**Total Approved Amount**	**Total Disbursed to Date**	**Total expensed** *(if available)*
AFG-T-UNDP	B1	B1	$ 11 million	$ 4.6 million	N/A
AFG-T-MOPH	N/A	N/A	$ 2.2 million	$ 0.5 million	N/A

In-country Global Fund status: Key updates, current conditions, challenges, and bottlenecks

The principle recipient (PR) UNDP and MOPH began implementing the activities. PR subcontracted five categories of GF activities with two local organizations (sub-recipients (SRs): contact investigation, TB in prisons, TB among children, payment to CHWs, and TB among IDPs. CTB assisted PR, NTP, and SRs with the coordination of activities in the provinces to avoid duplication and to promote cooperation, collaboration, and documenting the performance of the CTB/USAID and GF grant. In addition, GF was faced with challenges such as delay in payments to participants in the implementation that led to delayed implementation of activities. Unfortunately there is little that CTB could do to resolve these challenges.

In summary, the GF procurement process is going as planned. However, the activity implementation was delayed and the grant performance lays in category B1 for both UNDP and MOPH.

Challenge TB & the Global Fund: Challenge TB Involvement in GF Support/Implementation, any Actions Taken During this Reporting Period

As a member of the country coordination mechanism (CCM), the MSH/CTB Project Director assisted UNDP and MOPH/NTP in the SR selection process and in communication among the PR, SR, GF, and MOPH/NTP. CTB coordinated with the PR, SR, NTP, and MOPH through a TB taskforce and the CCM to ensure that planned activities are implemented as per schedule and to propose an amendment to the implementation plan. For example, CTB assisted the NTP in the selection process of the SR and the implementation of GF activities, such as conducting provincial and national Quarterly Review Workshops (QRWs). The implementation of activities was facilitated through five biweekly TB task force meetings.

4. Success Stories – Planning and Development

Planned success story title:	**Role of a nurse on DOTS implementation at public facilities in Kabul**
Sub-objective of story	**Patient-centered care**
Intervention area of story:	**Urban DOTS**
Brief description of story idea:	
Status update: The success story is ready and is attached to this report.	

5. Quarterly Reporting on Key Mandatory Indicators

Table 13: Multidrug-resistant TB (MDR-TB) cases detected and initiating second-line treatment in country (national data)

Quarter	Number of MDR-TB cases detected	Number of MDR-TB cases put on treatment	Comments:
Total 2010	19	0	
Total 2011	22	22	
Total 2012	38	38	
Total 2013	49	48	
Total 2014	90	90	
Jan–Mar 2015	14	13	
Apr–Jun 2015	22	22	
Jul–Sep 2015	18	18	
Oct–Dec 2015	26	26	
Total 2015	80	79	
Jan–Mar 2016	20	20	

Table 14: Number and percent of cases notified by setting (e.g., private sector, prisons) and/or population (e.g., gender, children, miners, urban slums) and/or case finding approach (CI/ACF/ICF)

		Reporting period					Comments
		Oct–Dec 2015	Jan–Mar 2016	Apr–Jun 2016	Jul–Sept 2016	Cumulative Year 2	
Overall CTB geographic areas	TB cases (all forms) notified per CTB geographic area *(List each CTB area below - i.e., Province name)*						
	Kabul	1,327	1,326				
	Kandahar	637	450				
	Herat	800	700				
	Nangerhar	1,004	600				
	Bamyan	134	80				
	Ghazni	325	300				
	Khost	392	300				
	Paktia	223	192				
	Paktika	198	155				
	Badakhshan	228	257				
	Takhar	333	361				
	Baghlan	378	432				
	Balkh	420	456				
	Faryab	217	251				
	Jowzjan	229	265				
	TB cases (all forms) notified for all CTB areas	6,845	6,125				
	All TB cases (all forms) notified nationwide (denominator)	9,388	8,189				
	% of national cases notified in CTB geographic areas	75%	75%				
Intervention (setting/population/approach)							

Community referral	CTB geographic focus for this intervention	14 provinces (all provinces listed above except Patria)	14 provinces (all provinces listed above except Patria)				The sub-contract with 1 NGO has been delayed, thus, CB-DOTS has not been implemented in Paktiya province. CTB will implement CB-DOTS there by itself
	TB cases (all forms) notified from this intervention	200	371				
	All TB cases notified in this CTB area	6,622	5,933				
	% of cases notified from this intervention	3%	6%				
Contact investigations	CTB geographic focus for this intervention	15	15				
	TB cases (all forms) notified from this intervention	159	191				
	All TB cases notified in this CTB area	6,845	6,125				
	% of cases notified from this intervention	2%	3%				
Reported by private providers (i.e., non-governmental facilities)	CTB geographic focus for this intervention	5 cities	5 cities				Jalalabad, Herat, Kandahar, Mazar, Kabul, and Bagram
	TB cases (all forms) notified from this intervention	322	368				
	All TB cases notified in this CTB area	4,188	3,164				
	% of cases notified from this intervention	7.7%	11.6%				
Reported by urban DOTS	CTB geographic focus for this intervention	4 cities	5 cities				Urban DOTS contributions to TB case findings in five cities of Jalalabad, Herat, Kandahar, and Kabul
	TB cases (all forms) notified from this intervention	2,155	1,831				
	All TB cases notified in this CTB area	3,768	3,164				
	% of cases notified from this intervention	57%	58%				
Children (0-14)	CTB geographic focus for this intervention	15	15				
	TB cases (all forms) notified from this intervention	1,154	918				
	All TB cases notified in this CTB area	6,845	6,126				
	% of cases notified from this intervention	16.8%	15%				
Reported by	CTB geographic focus for this intervention	5 cities	5 cities				There are six prisons covered by
	TB cases (all forms) notified from this intervention	52	56				

prisons	All TB cases notified in this CTB area	4,188	3,164				urban DOTS in Jalalabad, Mazar, Herat, Kandahar, Kabul, and Bagram
	% of cases notified from this intervention	1.3%	1.8%				

6. Challenge TB-supported international visits (technical and management-related trips)

#	Partner	Name of consultant	Planned quarter				Specific mission objectives	Status (cancelled, pending, completed)	Dates completed	Duration of visit (# of days)	Additional Remarks (Optional)
			Q 1	Q 2	Q 3	Q 4					
1	MSH	Paultre Desrosiers					Develop the SOP for extrapulmonary TB case notification and management	Complete		21 days	Consultant changed, originally Gloria Sangiwa
2	MSH	Navindra Persuad					Monitor overall project management	Pending		15 days	First STTA will occur in June 2016
3	MSH	Pedro Suarez					Monitor overall project management	Pending		15 days	This STTA will happen in July 2016
4	MSH	Gloria Sangiwa					Develop SOP for TB and diabetes and other comorbidity and program management	Pending		15 days	Planned for May 2016
5	MSH	Carol Douglis					Provide assistance on communication plan	Pending		15 days	Planned for August 2016
Total number of visits conducted (cumulative for fiscal year)								1			
Total number of visits planned in approved work plan								5			
Percent of planned international consultant visits conducted								20%			

7. Quarterly Indicator Reporting

Sub-objective:	1. Enabling Environment					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date Oct 2015 – Mar 2016**	**Comments**
1.1.1. % of notified TB cases, all forms, contributed by non-NTP providers (i.e., private/non-governmental facilities)	CTB intervention area	Quarterly	10% (500) 2014	15% (800)	571 (4.5%)	The community-based DOTS started late in October 2015. Thus, the target has not been achieved. CTB enhanced implementation and will compensate this deficit in the upcoming quarters. As this is CB-DOTS, contributions by only CHWs (no private sector).
1.1.12. AFGHANISTAN SPECIFIC: #/% of bacteriologically confirmed TB cases referred by community and CHWs	Gender, geographical location	Quarterly	18% (1,452) from CB-DOTS approach (2014)	20% (1,613 from CB-DOTS approach)	571 (4.5%)	See above

Sub-objective:	2. Comprehensive, high quality diagnostics					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
2.1.2. A current national TB laboratory operational plan exists and is used to prioritize, plan and implement interventions.	National: CTB does not invest in this area	Annually	1 (August 2015)			
2.2.6. Number and percent of TB reference laboratories (national and intermediate) within the country implementing a TB-specific quality improvement program i.e. Laboratory Quality Management System (LQMS).	National(CTB does not invest in this area)	Annually	0%(0/2) (2014)			
2.2.7. Number of GLI-approved TB microscopy network standards met	National(CTB does not invest in this area)	Annually	NA			
2.3.1. Percent of bacteriologically confirmed TB cases who are tested for drug resistance with a recorded result.	Geography	Quarterly	7% of all estimated MDR-TB cases (2014)		80/1250 (6.4%)	

Sub-objective:	3. Patient-centered care and treatment					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date**	**Comments**
3.1.3. Case notification rate	Gender, age category, geographical location	Annually	68% (2014)	73%	(71%) 160/100,000 population (2015)	National value is 129/100,000 population
3.1.5. #/% HFs implementing intensified case finding (e.g., using SOPs)	National	Annually	704 (2014)	754	745 (99%) (2015)	National
3.1.8. % of TB cases (all forms) diagnosed among children (aged 0-14)	Geographical location	Quarterly			918(15%) (Q1 2016)	
3.1.15. #/% of TB cases (all forms) diagnosed via urban DOTS or other urban TB approaches	Geographical location	Quarterly	5,007 (2014)	9,500	6,932 (54%) (2016	Commutative data from 5 Urban DOTS cities (Q1 and Q2 of the year tow project)
3.1.17. AFGHANISTAN SPECIFIC: # of household contacts of bacteriologically confirmed TB cases (index cases) screened for TB in Kabul	Geographical location	Quarterly	1,000 (2015)	2,600	1,601 (jan – March 2016)	
3.1.14. #/% of total cases notified that were referred or diagnosed via community based (Community Based) approaches	15 provinces	Quarterly	1,452/16% (2015)	1,613 (20%)	571 (4.5%)(Jan-Mar 2016)	CB-DOTS cumulative performances
3.2.22. #/% of TB patients followed by community-based workers/volunteers during at least the intensive phase of treatment	CTB intervention process (15 provinces)	Quarterly	18% (1,452) from CB-DOTS approach (2015)	20% (1,613) from CB-DOTS approach	714 (Oct 2015-Mar 2016	CB-DOTS cumulative performances
3.2.1. #/% of TB cases successfully treated (all forms) by setting (e.g.,	Five provinces: Kabul, Herat, Mazar,	Annually	69% for CTB cities (Cohort 2013)	72%	865/1,478 (59%) (Q1 2015)	This figure reflects only the success rate of all forms of TB cases registered in Q1 2015 in Kabul (Urban DOTS expanded in

private sector, pharmacies, prisons) and/or by population (e.g., gender, children, miners, urban slums)	Jalalabad, and Kandahar					August 2015 to other cities and we will be able to get the treatment outcomes on them in August 2016).
3.2.2. Treatment success rate for pediatric TB patients	Kabul	Quarterly		N/A		The data is not collected through NTP surveillance system (the data is aggregated)
3.2.15. #/% of prisons providing DOTS	Geographical location	Annually	2 (2015)	6	6 (2016)	
3.1.1. #/% of cases notified by setting (e.g., private sector, pharmacies, prisons) and/or population (e.g., gender, children, miners, urban slums) and/or case finding approach	CTB intervention process: Urban DOTS and CB-DOTS)	Quarterly	9,952 (2015) (8,500 in CTB cities + 1,452 from CB-DOTS)	11,013 (9,400 in CTB cities + 1,613 from CB-DOTS)	7503 (performance of urban DOTS in 5 provinces)	Urban DOTS has been initiated in four cities between August and September 2015. It was initiated in Mazar city in late November 2015.
3.1.4. Number of MDR-TB cases detected	National (CTB does not cover this area)	Quarterly	90 (2014)		80 (2015)	In total, 80 MDR-TB cases were notified by the NTP throughout Afghanistan in 2015.
3.2.7. Number and percent of MDR-TB cases successfully treated	National (No CTB investment)	Annually	67% (cohort 2011)		71% (27/38) (cohort 2012) and 63% (29/420(cohort 2013)	
3.2.20. #/% of HFs providing CB-DOTS services	Geography	Annually	450 (2014)	500	540 (Mar 2016)	

Sub-objective:	**5. Infection control**					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date (Oct 2015-Mar 2016)**	**Comments**
5.1.1. Status of TB IC implementation in health facilities	Geography	Quarterly	2 (2015)	3	**3**	

5.1.2. #/% of health facilities implementing TB IC measures with Challenge TB support (stratified by TB and PMDT services)	Geography	Quarterly	160 (2014)	190	185 (Mar 2016)	
5.1.5. #/% of high-risk sites in which TB IC is implemented with Challenge TB support (stratified by applicable sites: PMDT, HIV, mines, prisons, etc.)	Geography	Quarterly	40 (2015)	30	25 (Mar 2016)	
5.1.7. Community-based TB IC has been incorporated into national guidance	Geography	Annually	Yes (2015)	Yes		
5.2.2. #/% of HCWs screened (frequency of measurement based on policy)	Cadre	Annually	240 (2011)	600		
5.2.3. Number and % of health care workers diagnosed with TB during reporting period		Annually	7 (2011)	15		

Sub-objective:	**6. Management of latent TB infection**					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date (Oct 2015-Mar 2016)**	**Comments**
6.1.11. Number of children under the age of 5 years who initiate IPT	National, CTB intervention area	quarterly	1038 (2015)	2500	**4,046**	
6.1.2. % of eligible persons completing LTBI treatment, by key population and adherence strategy	National, CTB intervention area (measuring for children only)	quarterly	1038(100%) (2015)	2500 (100%)	**3,440**	

Sub-objective:	7. Political commitment and leadership					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date (Oct 2015-Mar 2016)**	**Comments**
7.2.1. % of NTP budget financed by domestic resources	geography	Quarterly	8% government spending in TB (global TB report 2014)	9%		This information is not available on quarterly basis
7.2.3. % of activity budget covered by private sector cost share, by specific activity	geography	Quarterly	NA	1 % of total CTB project	USD 40,000 (1.1% of total CTB budget)	51 private HFs covered by urban DOTS in five cities. Each HF dedicated one room for DOTS and one staff (part time). The cost of each room is estimated at $100 per month. The total estimated cost share during Jan–Mar would be $10,300. Also, private sectors' staff time estimated charge is $200 per facility, totaling $30,600 this quarter.
7.3.1. NTP leadership and management competency score (TBD)	geography	Quarterly	NA	30% improvement that of baseline		**This is planned for next quarter**
Sub-objective:	**8. Comprehensive partnerships and informed community involvement**					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date (Oct 2015-Mar 2016)**	**Comments**
8.1.3. Status of National Stop TB Partnership	geography	Quarterly	2 (2015)	3 end of Y2	2	
8.1.4. % of local partners' operating budget covered by diverse non-USG funding sources	National	Annually	0% (2014)	TBD		
8.2.1. Global Fund grant rating	National	Quarterly	B1 (2010-2015)		B1 (Mar 2016)	

Sub-objective:	9. Drug and commodity management systems					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date (Oct 2015-Mar 2016)**	**Comments**
9.1.1. Number of stock outs of anti-TB drugs, by type (first and second line) and level (ex, national, provincial, district)	geography, national (CTB does not address this area)	annually	0 (2015)			

Sub-objective:	10. Quality data, surveillance and M&E					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date (Oct 2015-Mar 2016)**	**Comments**
10.1.2. #/% of eligible health facilities reporting TB data in real time or at least quarterly via the ERR	Geography	Quarterly	555/79%	680/100%	91%(664)	The number of reported facilities increased to 734. Thus, denominator is 734 for this indicator
10.1.4. Status of electronic recording and reporting system	national	Annually	1 (2015)	1		
10.1.9. AFGHANISTAN SPECIFIC: #/% of health facilities using new TB recording and reporting forms	Geography	Annually	0 (2015)	680/100%		
10.2.1. Standards and benchmarks to certify surveillance systems and vital registration for direct measurement of TB burden have been implemented	national	Annually	Yes (2014)	Yes		

10.2.4. #/% of operations research, evaluation or epidemiological assessment study results disseminated (stratified by level of dissemination: report, presentation, publication)	national	Annually	4 (2014)	6		
10.2.6. % of operations research project funding provided to local partner (provide % for each OR project)	Geography	Annually	20%(2015)	50%		
10.2.7. Operational research findings are used to change policy or practices (ex, change guidelines or implementation approach)	national	Annually	Yes 2014	Yes		

Sub-objective:	**11. Human resource development**					
Performance indicator	**Disaggregated by**	**Frequency of collection**	**Baseline (timeframe)**	**End of year target**	**Results to date (Oct 2015-Mar 2016)**	**Comments**
11.1.3. # of healthcare workers trained, by gender and technical area	Gender, Cadre	Quarterly	510 (2015)	740	1,082	
11.1.5. % of USAID TB funding directed to local partners	geography	annually	3670 (2015)	12500		